

**TERMS AND CONDITIONS FOR LIMITED HEALTH INSURANCE AND SICKNESS DAILY ALLOWANCE COVER OF THE EXPAT®SERIES FOR LONG-TERM JOURNEYS PART II**

# EXPAT® RETIRED TARIFF

<b>1.</b>	<b>INSURANCE COMPANY:</b>	Würzburger Versicherungs-AG, Bahnhofstr. 11, D-97070 Würzburg		
<b>2.</b>	<b>POLICY HOLDER:</b>	BDAE Dienstleistungsgesellschaft mbH		
<b>3.</b>	<b>PARTIES ENTITLED TO INSURANCE:</b>	Natural persons		
<b>4.</b>	<b>INDIVIDUALS INSURABLE:</b>	Insurable are parties entitled to insurance who live outside the country whose nationality they hold as well as their family members, if they are insurable according to the conditions of insurance, part I, A, §1. A family member is defined as a spouse who shares the same household and children up to the age of 18 as long as the party entitled to insurance or his or her spouse is the parent or legal guardian. Family members who possess the nationality of the host country can also be insured. Persons are insurable up to the age of 65 years.		
<b>5.</b>	<b>CONTRACTUAL BASIS:</b>	Terms and conditions for limited health insurance and sickness daily allowance cover of the EXPAT®series for long-term journeys, part I and part II (Tariff EXPAT®RETIRED).		
<b>6.</b>	<b>AREA OF APPLICATION:</b>	The insurance cover applies worldwide except for the native country and except for the USA / Canada / Germany. Insurance cover is granted in the native country (except USA / Canada) for three months (accumulative) per insurance year. If insurance cover is taken out for less than one year, the insurance cover provided in the native country reduces proportionally.		
<b>7.</b>	<b>START OF COVER:</b>	At the time specified in the insurance confirmation document with consideration of conditions of insurance part I, A, § 4, but not before the stay abroad has begun.		
<b>8.</b>	<b>INSURANCE YEAR:</b>	From 1 April of each year respectively to 31 March of the following year.		
<b>9.</b>	<b>DURATION OF INSURANCE RELATIONSHIP:</b>	The duration of the insurance is unlimited under the terms and conditions of the group insurance contract.		
<b>10.</b>	<b>TERMINATION OF INSURANCE RELATIONSHIP:</b>	<ol style="list-style-type: none"> <li>1. The policyholder is obligated to inform the party entitled to insurance and the insured persons of notice of termination of the framework insurance agreement with two months notice before the termination takes effect.</li> <li>2. The insurance cover within the insurance agreement can be terminated for individual insured persons with one months notice to the end of the insurance year by the party entitled to insurance or the insured person in regard to the policyholder.</li> <li>3. If the party entitled to insurance and the insured person are not identical, a notice of termination only becomes effective, if the insured person concerned by the termination has attained knowledge of the termination declaration. The policyholder proves this accordingly to the insurance company at deregistration from the framework insurance agreement. The insured person concerned is in this case entitled to continue the insurance contract under designation of a future party entitled to insurance. An appropriate declaration must be made with-in two months after receiving the notice of termination.</li> </ol>		
<b>11.</b>	<b>PREMIUM PAYMENTS:</b>	The premium is an annual premium, which is made out in equal monthly instalments. It becomes due for payment in advance by the time of the end of each contractual year.		
<b>12.</b>	<b>DATA ON INSURED PERSON'S STATE OF HEALTH:</b>	In order to establish the state of health at the time of the conclusion of the contract, each person to be insured must truthfully and completely fill in a health questionnaire. Persons of 60 years of age or over who are to be insured must also submit on own expenses a health certificate issued by a doctor. The policy holder reserves the right to conduct a risk check and decides whether the application is granted or denied. Please observe the exclusion of benefits in the conditions of insurance.		
<b>13.</b>	<b>BENEFITS:</b>	<b>EXPAT®R-BASIS</b>	<b>EXPAT®R-PLUS</b>	<b>EXPAT®R-DENT</b>
<b>13.1</b>	<b>OUTPATIENT TREATMENT:</b>	100% of the amount invoiced for medically necessitated outpatient treatment as a private patient, radiological treatment, light, and other physical treatments, if prescribed by a doctor.	No benefits	No benefits

<b>13.2</b>	<b>INPATIENT TREATMENT:</b>	100% for medically necessitated inpatient treatment at a hospital and treatment necessitated accommodation for medically necessitated operations, X-rays, radiological treatment and diagnostics. As a private patient in a semi-private room abroad; in a standard room with statutory basic treatment in the native country. (Please note the terms and conditions of insurance Part I, B, §1 para. 6)	No benefits	No benefits
<b>13.3</b>	<b>PHARMACEUTICALS, BANDAGES AND MEDICINES:</b>	100%, if prescribed by a doctor and medically necessitated.	No benefits	No benefits
<b>13.4</b>	<b>DENTAL TREATMENT:</b>	100% of the invoiced amount for medically necessitated outpatient dental treatment in simple form. The insurance cover includes an annual checkup for preventive purposes, once in the insurance year, but does not include any prophylactic treatment.	No benefits	No benefits
<b>13.5</b>	<b>TOOTH REPLACEMENT:</b>	No benefits	No benefits	Notwithstanding the conditions of insurance part I, A, § 6, para. 2q insurance cover continues after expiration of the waiting period of 8 months for 80% of the costs for medically necessitated tooth replacement, to a maximum amount, however: - of EUR 500 per insurance year within the first three years of the policy and - EUR 2,000 in subsequent years. Benefits for insurance cover that was taken out or terminated during the year are calculated proportionally. Benefits for different insurance years cannot be transferred to other insurance years.
<b>13.6</b>	<b>PREVENTIVE CHECKUPS:</b>	No benefits	Preventive outpatient medical examinations for early recognition of cancer in accordance with statutory programmes that have been introduced in Germany.	No benefits
<b>13.7</b>	<b>BENEFITS FOR PREGNANCY AND DELIVERY:</b>	No benefits	No benefits	No benefits
<b>13.8</b>	<b>MEDICAL AIDS:</b>	No benefits	Notwithstanding the conditions of insurance part I, A, § 6, para. 2g insurance cover continues for the following aids, if medically necessitated and prescribed by a doctor: a) Visual aids costing up to EUR 50 per person insured and year of the policy, b) bandages, dressings, orthopaedic inserts and walking supports in simple design.	No benefits

<b>13.9</b>	<b>OTHER BENEFITS:</b>	<p>a) 100% of the transport costs to the nearest suitable hospital for inpatient treatment and for first-aid after an accident to the nearest suitable doctor and back.</p> <p>b) For medically necessitated return transport or conveyance to the permanent place of residence of the insured person, the insurance company will reimburse</p> <ul style="list-style-type: none"> <li>- up to EUR 5,000 within a continent,</li> <li>- up to EUR 10,000 between continents.</li> </ul> <p>If for the return journey an authorised ambulance aeroplane should be called for, the restriction to the benefit amount no longer applies. The most economical means of transport is to be selected for the return journey, so long as this is possible from the medical point of view. Medical necessity for a return journey is given, if sufficient medical care is not available in the country of residence. To prove the medical necessity of return transport, a certificate of the doctor treating abroad must be submitted.</p>	No benefits	No benefits
<b>14.</b>	<b>WAITING PERIOD:</b>	None	None	8 months for tooth replacement.
<b>15.</b>	<b>MONTHLY PREMIUM:</b>	EUR 124	EUR 55	EUR 38
		All premiums increase by 10% from the first month of the insurance year in which the insured person turns 50 years of age.		
		All premiums increase by 50% from the first month of the insurance year in which the insured person turns 65 years of age.		
<b>15.a</b>	<b>DEDUCTIBLE:</b>	EUR 250	EUR 0	EUR 0
		The deductible applies to each insured person per insurance year. The deductible for insurance cover which is required for less than one year is calculated proportionally.		
<b>16.</b>	<b>OTHER MATTERS:</b>	Changing of modules or adding an additional module is not permitted. No pension reserve fund will be established. You are recommended to take out a deferred insurance policy, e.g. with a statutory health insurance scheme.		

Stand: 01.08.2010

## MEDICAL ASSISTANCE FOR PERSONS INSURED BY BDAE AND MEMBERS OF BDAE



For fast and smooth processing of medical services anywhere in the world, the BDAE GROUP has integrated an Assistance Programme into its insurance concept. The BDAE makes its Assistance services – i.e. the aid, emergency and service offer – available to its insured and members in collaboration with the Assistance specialist med con team. The following services to insured and members are included:

### **24 H BDAE EMERGENCY PREPAREDNESS VIA +49 - 40 - 30 68 74 - 74**

- Multilingual 24-hour Emergency Hotline,
- More than 172 alarm centres in more than 100 countries,
- Information about (dental) medicine service providers (e.g. names, addresses and telephone numbers as well as consulting hours for doctors and dentists, hospitals and clinics within the region of the current place of residence),
- Patient advice in routine cases and emergencies as well as during crises that may compromise safety in the country of residence,
- Help and support to family members by means of provision of country specific health care data and information,
- Assistance in arranging treatment appointments at hospitals and with doctors for outpatient treatment,
- Organisation of hospital admission in the event of illness,
- Support in the obtention and shipment of prescription medicines (insofar as statutorily permitted),
- Organisation of interpreting and translation services,
- Access to worldwide medical information in German and in English,
- Advice and support in the event of loss of important documents and means of payment.

In addition to the services listed above, the BDAE assumes the costs for the services it covers, for which med con team seeks authorisation directly from the BDAE and its risk carriers. These services include:

- Organisation of emergency evacuations as well as transfers to appropriate hospitals in cases of medical necessity,
- Organisation and implementation of repatriations to a value of up to €250,000 per insurance event,
- Implementation of and cost assumption for body repatriation in the event of death, for up to €10,000.

These services are available to persons insured by BDAE and members of BDAE 365 days a year, 24 hours a day. Generally, a scope of services of this kind can only be taken advantage by large companies. Because of the strategic partnership of the BDAE with med con team, private individuals, too, can benefit from the Safety Package. To ensure smooth processing in your dealings with the Assistance company, please always have your BDAE policy or membership number ready when you contact med con team.

**MED CON TEAM**  
**ONE OF THE WORLD'S LEADING ASSISTANCE COMPANIES**

med con team is represented by partner companies in more than 100 countries worldwide, including the International Assistance Group (IAG). IAG is one of the largest Assistance networks worldwide, with 5,300 employees, 46 proprietary Alarm Centers and 74 million customers. Using the services of med con team simultaneously involves all the benefits of the IAG network. Overall, med con team has 36 flying ambulance providers in 16 countries, as well as 172 partner alarm centres and representative offices in more than 100 countries.

The Company was founded by Dr. Michael Weinlich, a surgeon and emergency medicine expert. On the basis of his long-time experience in the area of worldwide assistance and air rescue, Dr. Weinlich decided to make his expertise available to a wider public, and in faithful implementation of his leading principle: "The best possible medicine with simultaneous quality and cost transparency".

## PATIENT LEGAL EXPENSES INSURANCE FOR BDAE CLIENTS



### **NEW: PATIENT LEGAL EXPENSES INSURANCE WORLDWIDE FOR THE FIRST TIME**

In addition to your health insurance, BDAE has now arranged a patient legal expenses insurance for your stays abroad. This increase of benefits is provided on a complimentary-basis to your existing cover. Originally developed by the renowned legal insurer ARAG Group at the beginning of 2010, this product, following the cooperation between BDAE and ARAG, is now available on a worldwide basis.

### **WHAT IS INSURED?**

The policy responds to situations where the professional negligence of doctors or other medical personnel cause you serious harm. Although the relationship between patient and doctor is based on a high level of trust, even medical professionals are capable of making mistakes. In such situations, it is difficult for patients to assert and protect their rights while trying to resolve a complicated conflict about errors in treatment. Even more so when they are not able to communicate directly with the doctor, but have to address his professional indemnity insurers.

The policy covers – subject to a deductible of 500 Euro per claim – legal cases up to One Million Euro, worldwide. ARAG accepts all costs for legal and court expenses up to this limit. If required, ARAG will also recommend a lawyer specialised in healthcare law.

### **WHAT ARE TREATMENT ERRORS AND AN INCORRECT CONSULTATION?**

Treatment errors are not merely instances of a pair of scissors being forgotten in the abdomen during a surgery they can also include incorrect advice given about the dosage of a medicine. A treatment error can also be in the form of inappropriate or delayed treatment of a patient by a physician or surgeon. The failure of a physician or a surgeon to advise a patient about the necessity or risks of a treatment is also considered to be an act of professional negligence and hence would be covered under the policy. This not only applies to physicians but also to hospital staff, psychotherapists, pharmacists and nursing service providers. They are equate to physicians in the patient legal expenses insurance.

### **ABOUT ARAG**

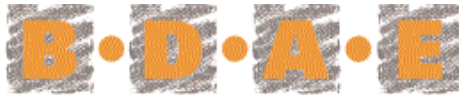
The ARAG Group is an internationally renowned independent provider of legal services and is the largest family-owned company in the insurance market. Apart from Germany, ARAG also operates in 12 European countries and in the USA, where it has taken a leading position in the legal insurance market. ARAG is also market leader with its legal insurance products in Spain and Italy. BDAE has been associated with ARAG since 2008 and the two companies have now developed the first legal expenses insurance for overseas stay and travel on a worldwide basis.

# CHECKLIST FOR APPLICATION

**WE KINDLY REQUEST THAT YOU REMEMBER THE FOLLOWING POINTS SO AS TO ENSURE THAT YOUR APPLICATION IS PROCESSED QUICKLY AND PROMPTLY**

<b>1.</b>	<b>THE APPLICATION MUST FILLED IN COMPLETELY AND IN BLOCK CAPITALS.</b>
<b>2.</b>	<b>PAYMENT METHOD DATA:</b>
<b>2.a</b>	Bank transfer of the premium is only possible once a year or every six months.
<b>2.b</b>	A direct debit is only possible from a German account on a monthly, quarterly, six monthly or annual basis. As an alternative, you can also pay the premium by credit card using the same payment method as for a direct debit.
<b>3.</b>	<b>THE APPLICATION MUST BE SIGNED BY THE APPLICANT AND ALL INSURED PERSONS WHO ARE OF FULL AGE.</b>
<b>4.</b>	<b>IF THE ACCOUNT HOLDER IS DIFFERENT FROM THE APPLICANT, THE SIGNATURE OF THE ACCOUNT HOLDER IS ALSO REQUIRED</b>
<b>5.</b>	<b>THE FOLLOWING MUST BE NOTED FOR THE RATES EXPAT GERMANY, EXPAT RETIRED, EXPAT 36/60 AND EXPAT 36/60 US 1000:</b>
<b>5.a</b>	<b>EXPAT GERMANY:</b>
	A health certificate or evidence of a German previous insurance must be submitted if the insured person has been resident in Germany for longer than 31 days. The health certificate must not have been issued more than 14 days previously.
<b>5.b</b>	<b>EXPAT RETIRED:</b>
	Information on the health declaration as well as the additional declaration must be submitted with the application. A health certificate which has not been issued more than 3 months previously must be submitted for persons aged 60 and over.
<b>5.c</b>	<b>EXPAT 36/60 UND EXPAT 36/60 US 1000:</b>
	Please indicate the occupation you will pursue abroad.
<b>6.</b>	<b>HEALTH CERTIFICATE EXPAT GERMANY AND EXPAT RETIRED:</b>
<b>6.a</b>	The health certificates must be issued in German or English and be legible.
<b>6.b</b>	Each question must be answered.
<b>6.c</b>	Questions answered with yes or questions that indicate an abnormal result require an explanation.
<b>6.d</b>	The explanation in the presence of the doctor must be signed by the applicant and the doctor.
<b>6.e</b>	The last page of the certificate must also be signed by the doctor.
<b>6.f</b>	If the R-Dent or G-Dent tariff is selected, a dental report is required.
<b>6.g</b>	The first and last name must be specified on each page of the findings.
<b>6.h</b>	Always specify your GP using their full name and the exact address.
<b>6.i</b>	If any inpatient treatment has taken place, it would speed up the inspection if corresponding discharge reports and reports on findings were submitted to us along with the health certificate.
<b>6.j</b>	If there are any further inquiries, please adhere to the deadlines specified in the letter of request as acceptance is otherwise not possible.

**WITH THESE REGULATIONS, WE CAN ENSURE THAT YOUR APPLICATION IS PROCESSED SMOOTHLY AND PROMPTLY. THANK YOU FOR YOUR UNDERSTANDING!**



B D A E G R U P P E

HEALTH INSURANCE FOR PERSONS LIVING ABROAD

APPLICATION EXPAT® RETIRED

APPLICANT / PARTY ENTITLED TO INSURANCE:

Form fields for Applicant/Party Entitled to Insurance: Surname, First name(s), Current occupation, BDAE membership no., Address, Phone, Fax, e-mail.

PAYMENT DETAILS:

Form fields for Payment Details: Payment type\*, Bank, Account no., Sort code, Credit Card (+6%)\*, Valid until, Card no.

Account / Card holder, if not applicant (please also sign below):

INFORMATION ON ADDITIONAL HEALTH INSURANCE:

Form fields for Information on Additional Health Insurance: Do you have additional health insurance\*?, Insurance no.:

THE FOLLOWING PERSONS ARE TO BE INCLUDED IN THE INSURANCE: (Please consider applicant)

Table with columns: Surname, First name(s), Nationality, Sex\* (m/f), Date of birth, Type of tariff\* (EXPAT® RETIRED: R-BASIS, R-PLUS, R-DENT), Planned country of residence, Monthly premium (EUR), Start of insurance (Month / Year).

(\*please tick)
I / we hereby apply for insurance cover as outlined by the terms and conditions for limited health insurance and sickness daily allowance cover of the EXPAT®-series for long-term journeys Part I and Part II (EXPAT® RETIRED tariff) for the persons listed above by registering them with the insurer as insured persons.
The insured persons or their legal guardians permit the insurer to request any information from third parties at any time which may be necessary to establish the state of health of the insured persons. For this purpose, the third parties are released from their obligation to secrecy.
The total premium must be paid in advance in accordance with the chosen payment method. I hereby give permission for the premiums to be debited from my account or credit card (see above). Note: the premium is due after confirmation of insurance cover has been received and no later than the beginning of the insurance. I / we am / are aware that the policy holder will not register the listed persons as insured persons with the insurer or will terminate their registration if the premium or other charges have not been paid in full due to the actions of parties entitled to insurance. I / we am / are also aware that we do not have insurance cover in this case.

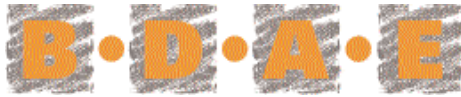
Place, date: Signatures:

(applicant or legal guardian of persons who are to be included in the insurance and all adults to be insured and possibly different account holder / card owner)

Insurer: Würzburger Versicherungs-AG
Policy holder: BDAE Dienstleistungsgesellschaft mbH

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SITZ DER GESELLSCHAFT: WILHELM-HERBST-STR. 5 • 28359 BREMEN • HRB 26444 HB • AMTSGERICHT BREMEN • GESCHÄFTSFÜHRER: BEATE SCHENK-MIKUTTA



HEALTH INSURANCE FOR PERSONS LIVING ABROAD

# ADDITIONAL DECLARATION FOR THE EXPAT® RETIRED APPLICATION

**APPLICANT / PARTY ENTITLED TO INSURANCE:**

Surname:	First name(s):	Current occupation:
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**THE FOLLOWING PERSONS ARE TO BE INCLUDED IN THE INSURANCE:** (Please consider the applicant!)

Surname, First name(s)	Nationality	Sex*		Date of birth	Commencement of insurance (Month / Year)
		m	f		

(\*please tick)

With our signature we confirm that we have read and understood the following limitation:

No insurance cover is granted for temporary stays in the native country that last longer than three months per insurance year. This also applies if the three-month limit is exceeded due to unexpected illness. (Exception: family members who are included in this insurance and who are nationals of the country of residence also have insurance cover at home).

My / our insurance broker has advised me not to cancel existing insurances which apply at home or to join the public health scheme of your home country or - if possible - to apply for additional insurance cover.

Place, date	Signatures: (applicant or legal guardian of persons who are to be included in the insurance and all adults to be insured and possibly different account holder / card owner)
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Insurer: Würzburger Versicherungs-AG  
 Policy holder: BDAE Dienstleistungsgesellschaft mbH

Stand: 01.08.2010

**HEALTH DECLARATION**

# TARIFF EXPAT® RETIRED

**APPLICANT / PARTY ENTITLED TO INSURANCE:**

Surname:	First name(s):
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Please answer all the questions below. Please also include ailments which you regarded as unimportant or which you did not view as illnesses, even if you did not receive treatment, but only had an examination or test or only took medicines and were not incapacitated. If you supply incorrect or insufficient information you may lose your insurance cover.

DETAILS ABOUT INSURED PERSONS:	FIRST PERSON	SECOND PERSON
The following questions must be answered for each insured person listed in the application according to the information supplied by the insured persons. In the case of minors, the questions must be answered in accordance with the information supplied by the guardian.  If there are more than two insured persons, please use additional copies of this form.	Surname: _____	_____
	First name(s): _____	_____
	Date of birth: _____	_____
	Size: _____ cm	_____ cm
	Weight: _____ kg	_____ kg

<b>1.</b> Do you currently suffer from ailments, illnesses, the effects of an accident, physical or mental disorders? (including teeth)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2.</b> Have you been taking medicines, alcohol or drugs on a daily or almost daily basis for the last five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3.</b> Is an examination, check-up, treatment or operation required at this time? Please also supply information on dental treatments, dentures, orthodontic measures, or paradontosis treatments.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4.</b> Have you had inpatient or outpatient examinations / treatments or operations by doctors, dentists, healers, psychologists or masseurs or have you been in hospital for the last five years? (Please also supply information about cures and stays at sanatoriums).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5.</b> If the EXPAT®RETIRED PLUS module has been applied for: do you have defective vision i.e. do you require glasses or contact lenses? Please give details (dioptr number).	<input type="checkbox"/> Yes <input type="checkbox"/> No Left: _____ Right: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Left: _____ Right: _____

Please give details on the questions which you answered with "Yes" (state the person(s) and the number(s) of the questions / use an additional sheet of paper if necessary):

Insured person	Question no.	Detailed description of illness, type of ailment	Treatment(s) received inpatient / outpatient?	Dates	Do you still suffer from consequences? If yes, please give details.

Please give the names of the doctors who can supply more detailed information. If all questions have been answered with "No", please indicate the name, specialist field and exact address of the doctor who can supply the most up-to-date information.

First Person: \_\_\_\_\_

Second Person: \_\_\_\_\_

Place, date: \_\_\_\_\_ Signature: \_\_\_\_\_  
 (applicant or legal guardian of persons who are to be included in the insurance and all adults to be insured and possibly different account holder / card owner)

Stand: 01.08.2010

**HEALTH CERTIFICATE FOR APPROVAL OF AN APPLICATION FOR HEALTH INSURANCE EXPAT® RETIRED  
EXAMINATION COSTS WILL BE BORNE BY THE APPLICANT! TO SUBMIT WITH AGE OF 60 AND ABOVE**

# HEALTH CERTIFICATE

**APPLICANT / PARTY ENTITLED TO INSURANCE:**

Surname:	First name(s):	Date of birth:
Address:		

1.	DECLARATION TO THE DOCTOR:	ANSWER	IF YES: WHICH, TREATED WHERE (DOCTOR), DIAGNOSIS	WHEN?
1.a	Are you currently suffering from complaints, illnesses or the results of accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.b	Do you or have you suffered from a chronic or repetitious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.c	Have you been examined, advised or treated by medical staff (e.g. doctors, consultants, medical practitioners, psychologists, masseurs..) in the last three years or have you been unable to work - even temporarily?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.d	Have operations or treatment been performed, planned or advised?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.e	Has hospital treatment (including clinics, sanatoriums etc.) taken place in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.f	Have blood examinations been performed? With which results?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.g	Has an HIV infection been determined, e.g. by an AIDS test?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.h	Have you had or are you engaged in cytostatic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.i	Do you or have you regularly imbibed medicines, alcohol or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.j	Do you have impaired sight or do you require an aid to vision (e.g. spectacles, contact lenses)? Dioptré?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.k	Which doctor do you usually consult? (Regular GP)			
1.l	How many natural teeth (excluding wisdom teeth) have you lost without final replacement?			
1.m	Is dental treatment necessary, particularly with regard to dentures, dental surgery or parodontosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1.n	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

I hereby confirm with my handwritten signature that the above declaration is a part of my application for health insurance and that the I have answered the above questions dictated to me individually by the doctor personally and truthfully.

Place / Date:
Signature of the applicant:

Anamnesis performed (Stamp / Signature of the doctor):
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Stand: 01.08.2010

<b>EXAMINATION DIAGNOSIS FOR:</b>			
Surname:		First name(s):	
<b>2. GENERAL:</b>			
		<b>ANSWER</b>	<b>DIAGNOSIS / DEVIATIONS / EXPLANATION</b>
<b>2.a</b>	Have you examined, advised or treated the person in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2.b</b>	Height:	cm	
	Weight:	kg	
<b>2.c</b>	Do you consider the skeleton and locomotion to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2.d</b>	Do you consider the skin, mucous membranes and lymph glands to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2.e</b>	Do you consider the sensory organs to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2.f</b>	Do you consider the nervous system and psyche to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2.g</b>	Are the reflexes normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2.h</b>	Do you consider the hormonal system to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2.i</b>	Is the thyroid gland normally shaped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3. CARDIOVASCULAR SYSTEM:</b>			
<b>3.a</b>	Pulse at rest		
	After 10 knee bends		
	Return to normal in		minutes
<b>3.b</b>	Blood pressure at rest	/	mm Hg
	After 10 knee bends	/	mm Hg
<b>3.c</b>	Can unhealthy heart sounds be heard?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3.d</b>	Is the heart arrhythmic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3.e</b>	Is the heart enlarged or displaced?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3.f</b>	Are there any signs of insufficiency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3.g</b>	Does the patient have dyspnoea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>4. BLOOD VESSELS:</b>			
<b>4.a</b>	Is the patient oedemic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>4.b</b>	Does the patient have haemorrhoids, varicose veins? (type? / extent?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>4.c</b>	Does the patient have scars, ulcers? (type? / extent?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>5. RESPIRATORY ORGANS:</b>			
<b>5.a</b>	Does the patient suffer from hoarseness, coughs, bronchitis? (since when? extent?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>5.b</b>	Is the rib cage deformed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>5.c</b>	Are the results of the percussion and auscultation examinations normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>5.d</b>	Do you consider the respiratory organs to be healthy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6. DIGESTIVE AND ABDOMINAL ORGANS:</b>			
<b>6.a</b>	Signs of illness on the tongue, tonsils, throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6.b</b>	Are the examination results of the abdomen normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6.c</b>	Is the liver enlarged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6.d</b>	Is the pancreas enlarged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6.e</b>	Does the patient suffer from a rupture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6.f</b>	Unhealthy diagnosis of the digestive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

EXAMINATION DIAGNOSIS FOR:			
Surname:		First name(s):	
<b>7. URINAL AND SEXUAL ORGANS:</b>			
		<b>ANSWER</b>	<b>DIAGNOSIS / DEVIATIONS / EXPLANATION</b>
<b>7.a</b>	Is the condition of the renal capsule normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>7.b</b>	urine examination:	protein <input type="checkbox"/> Yes <input type="checkbox"/> No	sediment:
		sugar <input type="checkbox"/> Yes <input type="checkbox"/> No	
		bile pigment high <input type="checkbox"/> Yes <input type="checkbox"/> No	
	exterior condition:		
	pathological components:		
<b>7.1 REGARDING WOMAN:</b>			
<b>7.1a</b>	Are you suspicious of an organic disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>7.1b</b>	Pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	in _____ month
<b>8. MISCELLANEOUS:</b>			
<b>8.a</b>	What other disorders and still unnamed diagnoses were found?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>8.b</b>	Are there signs of an immune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**OTHER ASPECTS THAN THE EXAMINATION RESULTS ARE SOMETIMES DECISIVE IN THE EVALUATION OF THE RISK. PLEASE DO NOT DISCLOSE ANY INFORMATION OF THE INSURANCE RISK.**

Place / Date

Stamp / Signature of the doctor

**DETAILS OF THE DENTAL STATUS ONLY NECESSARY IF APPLICATION INCLUDES MODULE EXPAT®R-DENT**

## DENTAL STATUS

### DIAGNOSIS OF ALL TEETH

<b>DIAGNOSIS</b>																	<b>DIAGNOSIS</b>
	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	
<b>DIAGNOSIS</b>																	<b>DIAGNOSIS</b>

### DIAGNOSIS / LEGEND:

<b>f</b> missing teeth	<b>e</b> replaced teeth	<b>K</b> crowned teeth	<b>b</b> bridged teeth
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Place / Date

Stamp / Signature of the dentist

# TO LIVE WHERE OTHERS GO ON HOLIDAY - BUT WHAT HAPPENS IF I FALL ILL?

## THE GROUP MAKES IT POSSIBLE

A special health insurance for overseas residents offers protection when other insurances do not provide complete cover or no cover at all. And at a very affordable price. And without a fixed time limit, since we know that you are living abroad permanently. And (almost) without local limitations, since the insurance cover applies worldwide except in the USA, Canada and Germany. Even at home (except in the USA / Canada) we provide cover for up to three months per insurance year. German law applies.

The basis is a special group contract which does not cover an individually calculated risk, but which, instead, is based on the "average risk" of the whole group. And since in many cases there is the option of using other, e.g. statutory health insurances at least to some extent, your premium will also be affordable. For this reason, it is not an exaggeration to speak of a large insurance community which has the same objective, but different prerequisites. Would you like to join?

## EXPERIENCE HELPS

EXPAT®RETIRED is the oldest and experienced tariff in its class on the market and is sold since 1997 very successfully. This is the result of engaging skilled sales partners, careful checking of applicants and informing the insured precisely about their insurance cover. Our insured community as well experienced the rough conditions of demographic changes and dramatical increase of health costs. Nevertheless we are more convinced than ever to offer you worldwide, except in the USA, Canada and Germany, an excellent relation of costs and benefits.

## MODULAR INSURANCE COVER

People have different needs and the size of the wallet may set limits. We understand this and have therefore developed modular insurance cover. For the legally binding and detailed benefits of the individual modules and prerequisites for compensation, please consult the terms and conditions of insurance.

And here is a short preliminary summary for you:

## THE MAIN MODULE EXPAT®R-BASIS

This has been designed to protect you against unforeseeable and incalculable risks. Costs for inpatient and outpatient treatment are covered, including drugs prescribed by a doctor. Also included are medically necessitated pain-relieving dental treatments and fillings, however only basic ones. And should you become ill while on holiday, we will cover the costs of transporting you to your place of residence, if medically essential, up to the specified limits. And since you are a private patient you can choose your doctor and hospital freely, in your native country, however, you are only covered for standard inpatient treatment.

For all these benefits you only have to pay an deductible of EUR 250 per insurance year and insured person. The basic monthly premium is EUR 124 per insured person.

## THE ADDITIONAL MODULE EXPAT®R-PLUS

This extends the insurance cover: Preventive outpatient medical examinations for early recognition of cancer and certain simple medical aids are also covered. The basic monthly premium is EUR 55 per insured person. Please note that you can only be covered by the additional module if you are also covered by the main module and that it is not possible to include the additional module at a later date or to cancel it before the insurance term has ended.

## THE ADDITIONAL MODULE EXPAT®R-DENT

This complements your dental coverage of the main module at a very reasonable price: you can also insure medically necessitated tooth replacement up to 80%. Please note the different benefit rates and waiting period of eight months. The basic monthly premium is EUR 38 per insured person. Please note that you can only be covered by the additional module if you are also covered by the main module, and that it is not possible to include the additional module at a later date or to cancel it before the insurance term has ended.

## AGEING IS HUMAN...THEN WHAT?

We would like to continue serving you. However, in the past we have had the experience that the costly treatments for older people have a significant impact upon the average risk of the group. For this reason, we have decided to limit the age of applicants to 65 years of age. Of course, you can remain insured beyond this age. However, to cover the increased cost of treatments for old people, the premiums listed above increase by 10% at the beginning of the insurance year in which you turn 50 years old and by 50% at the beginning of the insurance year in which you turn 65 years old.

# BEWARE!

Others like to include it in the small print, but we would like to explicitly draw your attention to a few details: this may prevent misunderstanding and complications.

## **WHAT ABOUT "HOLIDAYS AT HOME"?**

Insurance cover extends to the country whose nationality the insured person possesses (except USA / Canada), but only for up to three months per insurance year. This maximum period is accumulative i.e. if you go home on several occasions, the time you spent there is added together. And please consider: sometimes the three-months limit is exceeded unintentionally, for example, as a result of illness and that you cannot be transported. Even in this case the insurance cover for the current insurance year in Germany will end. You are only insured for standard inpatient treatments at your native country.

## **WHAT IS THE HEALTH DECLARATION NEEDED FOR?**

Administration is an essential cost factor in the insurance sector. We would like to keep administrative costs to a minimum. For this reason we would like to know about your current state of health, so that we can settle claims more quickly when an insured event occurs. If, for example, it turns out at the beginning of the insurance relationship that treatment is necessary due to existing illnesses or accidents or their consequences or if you even deliberately decide to go abroad to have these treated, we will not provide insurance cover. For this reason, it is important that you give us the names of your doctors so that we can request information from them if necessary. Please answer these questions with care. If we later find out that you have overlooked important information, the insurer is permitted to terminate the contract. If you are 60 or older at the time of taking out insurance we must also ask you to provide an additional health certificate which must not be older than three months and which you must pay for.

## **WILL THE PREMIUMS REMAIN STABLE?**

It is also in our interest to ensure the stability of premiums as this promotes the acceptance of this health insurance and will, from a mathematical point of view, result in a large, stable group. Regrettably, however, the costs for medical treatments tend to increase disproportionately. For this reason, it is likely that adjustments to the premiums or benefits (e.g. an increase of the deductible) may occur. The terms and conditions of insurance permit such adjustments at the beginning of a new insurance year, i.e. on April 1. If this becomes necessary, you will be notified at least two months before the end of the insurance year so that you have enough time to decide whether you wish to stay insured.

## **WHEN DOES INSURANCE COVER COMMENCE?**

At the time specified in the insurance confirmation document with consideration of conditions of insurance part I, A, § 4, but not before the stay abroad has begun. Please note that you will be charged for any costs which may be incurred due to paying your premium (money transfer charges or fees for paying in a cheque). Please also consider the consecutive premium payments in order to ensure that your insurance cover is not terminated. If possible, use direct debit.

## **IS "EXPAT®RETIRED" SUFFICIENT?**

Generally, the EXPAT®RETIRED tariff provides high-class health insurance cover. However, it is not guaranteed that you will be allowed to change to a different health insurance at a later date and no pension reserve fund will be established. Especially for old people this could mean that changing to a different insurance is virtually impossible or unaffordable.

Please consider that the limited cover in the native country could cause problems: Sometimes the three-months limit is exceeded unintentionally, for example, as a result of illness and that you cannot be transported. Or your plans change and you decide to return home.

With other words: You can be pretty sure that EXPAT®RETIRED will cover you lifelong if you wish so, but you should not totally rely on this. For this reason, we strongly recommend that you do not cancel any existing insurance cover you may have under the public health scheme or suspended insurance cover in your home country. Please ask us if you require help.

# OKAY, I AGREE! WHAT MUST I DO NOW?

Thank you for letting us help you! Please fill in the complete application form. When the policy holder has received the application form you will receive a confirmation of the framework insurance agreement and you will also get a form which you can use to make a claim.

## AND THIS IS HOW YOU PAY:

The monthly premiums are - according to the terms and conditions - related to the yearly premium. The computing of the yearly premium is always performed until the end of the insurance year, i.e. till 31st of march.

An example:

You have applied for EXPAT®RETIRED with an initial commencement on 1st of July. The first payment will be due until 31st of march of the following year, i.e. it includes 9 monthly premiums. On 1st of April the next yearly premium will be due, including the regular 12 monthly premiums and being due again year by year.

Some insured parties cannot afford to pay the contractual yearly premium in total or do not want to. We therefore offer the possibility to pay the premium in several installments. Though this causes higher administrative costs a surcharge becomes due:

- For two yearly installments (due for 6 monthly premiums each on 1st of April and 1st of October) a loading of 2% on the insurance premium will be charged
- For quarterly installments (due for 3 monthly premiums each on 1st of April, 1st of July, 1st of October and 1st of January) a loading of 3% will be charged
- For monthly installments a loading of 5% will be charged.

If you have an account in Germany, the policy holder will deduct the premium from your account by direct debit. You must fill in a direct debit agreement when you fill in your application form. If your bank pays the direct debit and you do not call back the money, you don't have to do anything else. You can also pay by credit card at a loading of 6% on the insurance premium or you can transfer the money to the account mentioned in the letter confirming that you have been included in the group contract. We apologize that bank charges for international payments have to be contributed from your side.

## YOU WANT TO CANCEL YOUR INSURANCE?

You can cancel the insurance with one month's notice at the end of each insurance year. If you surrender your place of residence abroad and permanently return to your native country during the insurance year, you can also cancel the insurance at the end of the subsequent month after your return. You will then be refunded for the months you do not require insurance cover.

**TERMS AND CONDITIONS FOR LIMITED HEALTH INSURANCE AND SICKNESS DAILY ALLOWANCE COVER OF THE EXPAT®-SERIES FOR LONG-TERM JOURNEYS PART I**

**PART A - GENERAL PROVISIONS  
VALID FOR ALL THE INSURANCE POLICIES AND THE  
RESPECTIV TARIFFS LISTED IN PART B**

**§ 1 INSURABLE PERSONS AND INSURABILITY**

So far as has not been agreed to the contrary, the following shall apply:

1. The application of insured persons in the framework insurance agreement can only be submitted by the party entitled to insurance. Parties entitled to insurance are juridical and natural persons according to the respective underlying tariff conditions.
2. Natural persons may be insured.
3. Not insurable and despite premium payment not insured are
  - a) Persons who are in need of constant care. A person is in need of care if he/she for the most parts needs external help in order to manage the tasks of daily life.
  - b) Persons who are constantly excluded from participating in daily life. For this classification, in particular the mental state and the objectiv life circumstances of the person must be considered.
4. No insurance cover is granted for insured persons, who have their main place of residence in the Federal Republic of Germany.
5. Natural persons with a limited residence permit for the Federal Republic of Germany may not be insured, if at the time of applying for registration in the framework insurance agreement the entire insurance duration of all health insurance agreements concluded during the visit exceed a period of 5 years.

**§ 2 CONCLUSION AND DURATION OF THE INSURANCE CONTRACT**

1. The framework insurance contract will be concluded between the insurance company and the policy holder for the duration of a year. The framework insurance contract will be extended by one year if notice of termination is not given with a term of notice of three months to the expiry date.
2. The legal regulations on the extraordinary right to give notice of termination remain unaffected.
3. At termination of the framework insurance agreement, the insurance company will offer the insured persons continuation of the insurance cover.

**§ 3 PREMIUM, BENEFIT ADJUSTMENT, INSURANCE YEAR**

1. The policyholder is entitled to deregister individual insured persons from the framework insurance agreement because of non-payment of the premium.
2. Insurance company shall be entitled to make changes in the premium level or the extent of the benefits at the beginning of a new insurance year, provided that it notifies the policyholder of this with a term of notice of three months to the end of the agreed tariff insurance year.

3. The insurance year will be defined in the conditions of insurance for health insurance and sickness daily allowance cover of the EXPAT® -series for long-term journeys conditions of insurance part II.
4. The policyholder shall be obliged to give the party entitled to insurance and the insured person written notice of an adjustment of the premium level or of the level of benefits paid within a term of two months to the end of the agreed tariff insurance year.

**§ 4 SCOPE, START, DURATION, AND END OF INSURANCE COVER**

The insurance company shall offer insurance cover to insured persons, who are resident for a limited time in the context of a limited visit to the agreed tariff area in the context of these conditions of insurance. So far as has not been agreed to the contrary, the following shall apply:

1. The insurance cover starts for the insured person after binding registration into the framework insurance agreement at the time (start of insurance) specified in the insurance confirmation document,
  - a) however not before start of the stay of the insured person in the agreed tariff area;
  - b) not before effectiveness of the insurability of the insured person according to tariff;
  - c) not before payment of the premium;
  - d) not before expiration of waiting periods agreed according to tariff.
2. No insurance cover is granted for claims occasioned before or at start of insurance.
3. No benefits will be paid for claims occasioned during the waiting period as agreed in the tariff.
4. The maximum duration of insurance cover for the insured person is defined in terms of the relevant tariff.
5. Insurance cover for individual persons insured comes to an end, even in connection with pending claims, with
  - a) end of the insurance relationship of the insured person, at the latest however upon expiration of the maximum duration of insurance of the select ed tariff;
  - b) deregistration from the group of persons insured by the party entitled to insurance, taking into account the terms of notice and conditions defined in the tariff;
  - c) death of the person insured;
  - d) with the ending of the insurability of an insured person according to conditions of insurance part I, A, §1;

- e) at the end of the month following termination of the temporary visit of the insured person in the agreed tariff area or final return of the insured person to their native country;
- f) as soon as the tariff terms on the insurability of an insured person are inapplicable;
- g) with termination of the framework insurance agreement between the insurance company and the policy holder.

### **§ 5 OBJECT OF INSURANCE COVER AND SCOPE OF INSURANCE BENEFITS**

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company shall offer insurance cover for urgent and unexpected insured events occurring during the stay in the agreed tariff area.
2. The insurance cover results from the insurance confirmation, these conditions of insurance, the selected tariffs, statutory regulations of the Federal Republic of Germany.

### **§ 6 GENERAL LIMITATIONS OF THE OBLIGATION TO PAY BENEFIT**

So far as has not been agreed to the contrary, the following shall apply:

1. Insurance cover is not granted for damage occasioned by active participation in strikes, war, war-like events, civil disturbance, damages by nuclear energy, as well as for such events, resulting from intentional activities of the policyholder, the party entitled to insurance or the insured person.
2. There is no obligation to pay benefit:
  - a) On account of illnesses and complaints including their consequences existing and known at start of the insurance cover. Furthermore, there is no insurance cover for the consequences of such illnesses and accidents, which have been treated in the last six months before start of insurance.
  - b) For spa and sanatorium treatments as well as rehabilitation measures organised by party legally responsible for rehabilitation;
  - c) For treatments during a stay in a spa or a health resort, even if this involves a stay in hospital. This limitation shall no longer apply if the person insured has his/her constant place of residence there or if he/she becomes unable to work as a result of a sickness independent of the purpose of his/her visit or as a result of an accident that has occurred there, so long as this results, on medical testimony, in his/her being unable to journey home. This limitation also shall no longer apply if and to the extent that the insurance company has given written consent to benefit being paid before the start of residence abroad.
  - d) In consequence of an accommodation occasioned by the need of lingering illness, care or custody;
  - e) For the treatment of mental or emotional disturbances, or for hypnosis, psychoanalysis or psychotherapy;
  - f) For immunisation measures;
  - g) For medical aids;
  - h) For treatment of sterility, including in vitro fertilisation well as pertinent preliminary examinations and subsequent treatments;
  - i) For preventive medical examinations;
  - j) For treatments by spouses, parents, children or persons living together in the immediate domestic circle or persons living together with the insured person within his/her own or guest family. Costs of materials will be reimbursed in keeping with the given tariff.

- k) For treatment on account of such illnesses, including their consequences, or consequences of such accidents as are occasioned through professional participation in sporting competitions organised by sporting federations and associations or prenotory measures related to these, or such as are recognised as war injuries and are not explicitly included in the insurance cover.

- l) On account of withdrawal measures including courses of withdrawal treatment;

- m) On account of such illnesses, including their consequences, which arise as a result of the person's having neglected to obtain the protective inoculations recommended by the World Health Organisation or prescribed by statute, unless there should be medical reasons why protective inoculation cannot be carried out. In this case, the medical reasons are to be proved to the insurance company by the submission of a doctor's certificate.

- n) For treatment of a dependency syndrome and its consequences;

- o) For attempted suicides and their consequences;

- p) For organ donations and their consequences;

- q) For tooth replacement (such as e.g. pivot teeth, insert fillings, crowns, implants) and orthodontic treatment, occlusive overlay aids and gnathologic measures.

Note: Please also regard the Special Obligations on exclusions in the conditions of insurance, part I, B.

### **§ 7 OBLIGATIONS AND CONSEQUENCES OF FAILURE TO OBSERVE TO OBLIGATIONS**

1. Policyholder, parties entitled to insurance and insured person are obligated, after occurrence of the insured event
  - a) To avoid everything that could lead to an unnecessary increase in costs;
  - b) To immediately notify the insurance company or its agent of all damages that could presumably exceed a sum of EUR 1,000.00,
  - c) To permit the insurance company or its agent to make all reasonable examinations regarding the cause and amount of its duty to pay benefits, provide all relevant information in this connection, to submit original documents, and submit a death certificate in the case of death.
2. If required by the insurance company, the insured person is obligated to be examined by a doctor assigned by the insurance company.
3. Start and end, as well as an interruption of a stay in the area according to tariff, as well as the presence of the tariff terms concerning insurability must be proved by the insured person on request of the insured company in the case of benefit.
4. If the policy holder, the party entitled to insurance or the person insured willfully infringes one of the contractually agreed obligations, the insurance company shall be released from its obligation to pay benefits. In the case of a grossly negligent infringement of the obligation, the insurance company is entitled to reduce the benefits by an amount commensurate with the seriousness of the fault of the policyholder, the party entitled to insurance or the person insured. The onus of proving that there has been no gross negligence rests with the policyholder, the party entitled to insurance or the person insured.
5. The party entitled to insurance and the person insured are obligated to immediately communicate changes of address to the policyholder.

### **§ 8 PAYMENT OF INSURANCE BENEFITS**

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company shall be obliged to pay out benefits only if the follow-

ing documentary proof is supplied, which then become the property of the insurance company:

- a) Paid original receipts, which must carry the first name, surname and date of birth of the person treated, name and address of the doctor treating the patient, the description of the illness, nature of the services provided by the treating doctor according to type, place and treatment period. If compensation may be claimed under another insurance contract in connection with an insured event and if the claim has first been asserted for the other contract, then duplicates of the invoices will be considered sufficient, provided that the other insurance company has made a note on the document of the benefit paid.
  - b) Prescriptions must be presented together with the doctor's bill, the bill for pharmaceuticals and medical aids together with the prescription.
  - c) Proof of the amount of costs, which would have ensued in the case of a regular return journey, if benefits are asserted for a medically necessitated return transport. Furthermore, a doctor's certificate, which should clearly demonstrate the medical necessity of return transport, must be submitted.
  - d) For the assertion of claims in connection with conveyance of the body or funeral costs an official death certificate and medical certificate giving the cause of death must additionally be submitted.
2. Costs that have been incurred in a foreign currency will be converted into the currency valid in Germany at the exchange rate of the day on which the receipts are received by the insurance company, unless the foreign currency required for payment of the invoice was acquired at a less favourable rate and that this was caused by a change in the currency valuation.
  3. Costs incurred for the payment of insurance benefit by banker's draft to a foreign country, or for special forms of fund transfer which have been agreed on, will be deducted from the benefit paid.
  4. Claims to insurance benefit can neither be assigned nor given in pledge.
  5. In connection with examining the benefits to be provided, it may be necessitated for the insurance company to obtain personal-related health data within the legally permitted scope. If the party entitled to insurance or insured person fail to consent to this and if the insurance company as a result, is unable finally to determine the amount and scope of its obligation to provide benefits, the due date of payment shall be suspended. The same applies if the institutions or persons who are requested to provide information are not released from their duty of secrecy vis-à-vis the insurance company.
  6. One month after notification of a claim, the minimum amount which is payable as matters then stand may be claimed as a payment on account. The said period stops running as long as the insurance company's examination of the claim is hindered by fault on the part of the policyholder, the party entitled to insurance, the insured person.
  7. Claims under this framework insurance agreement shall become time-barred after three years. The limitation period begins at the end of the year in which the benefit may be demanded.

#### **§ 9 COMPENSATION FROM OTHER INSURANCE CONTRACTS AND CLAIMS AGAINST THIRD PARTIES**

1. If compensation may be claimed under another insurance contract in an insured case, the other contract shall take precedence over this contract. This applies likewise, even if a subordinate liability has also been agreed upon in one of these insurance contracts, irrespective of when the other insurance contract was concluded. If the insured event was first communicated to the insurance company via this framework insurance agreement, the insurance company will pay in advance and will contact the other insurance company directly concerning distribution of costs.
2. Claims of the policyholder, the party entitled to insurance or the insured person against third parties pass to the insurance company to the statutory extent,

as far as the insurance company has reimbursed the damage. If necessary, the policyholder, the party entitled to insurance or the insured person is obligated to provide a statement of assignment to the insurance company. The insurance company's obligation to provide benefits is suspended until the statement of assignment has been submitted.

3. Claims of the policyholder, the party entitled to insurance or the insured person against a medical practitioners due to excessive fees pass to the insurance company to the statutory extent, if the insurance company has reimbursed the appropriate bills. If necessary, the policyholder, the party entitled to insurance or the insured person are obligated to assist during assertion of claims. Furthermore, the policyholder, the party entitled to insurance or the insured person are obligated, if necessary, to provide a declaration of assignment to the insurance company. The insurance company's obligation to provide benefits is suspended until the declaration of assignment has been submitted.

#### **§ 10 OFFSET**

Policyholder, the party entitled to insurance or the insured person is only entitled to a set-off against claims of the insurance company in the case of undisputed or finally asserted counterclaims.

#### **§ 11 DECLARATIONS OF INTENTION AND NOTIFICATIONS**

Declarations of intention and notifications to the insurance company require the written form (Letter, fax, e-mail, electronic data medium, etc.). The person insured has an intrinsic right to assert claims based on the contract against the insurance company.

#### **§ 12 APPLICABLE LAW / LANGUAGE OF THE CONTRACT**

German law shall apply unless international law takes precedence. The language of the agreement is German.

#### **§ 13 SURPLUS SHARING**

The insurance specified here is not entitled to surplus.

#### **§ 14 SUPERVISORY AUTHORITY AND OMBUDSMAN**

The responsible supervisory authority for complaints is the Bundesaufsichtsamt für Finanzdienstleistungen, Graurheindorfer Straße 108, 53117 Bonn.

If you should not be satisfied with a benefit or a decision of the insurance company, please contact the insurance company directly. The insurance companies are members of the Verein Versicherungsombudsmann e.V. This gives you the possibility as a special service to address the independent and neutral Ombudsmann, if you should not agree to a decision. The procedure is free of charge.

The address of the Versicherungsombudsmann e.V. for foreign travel HI is:

Ombudsmann  
Private Kranken- und Pflegeversicherung  
Postfach 060222,  
10052 Berlin  
Tel.: 0180 / 255 04 44  
Fax: 030 / 20 45 27 85  
E-mail: ombudsmann@pkv.de  
www.pkv-ombudsmann.de

Complaints can however also be addressed to the above-mentioned supervisory authority responsible for the insurance company.

### **PART B – SPECIAL PROVISIONS FOR INDIVIDUAL INSURANCES**

#### **THE RELEVANT SECTION APPLIES IN DEPENDENCE ON THE INSURANCE COVER AND TARIFF SELECTED**

#### **SECTION I HEALTH INSURANCE FOR LONG-TERM JOURNEYS (ONLY VALID, IF CONTAINED IN THE SELECTED TARIFF)**

#### **§ 1 OBJECT OF INSURANCE**

So far as has not been agreed to the contrary, the following shall apply:

1. Grounds of a claim shall be the medically necessitated treatment of a person insured on account of illness or in consequence of an accident. The claim shall be considered to begin with the treatment, and shall end when medical findings indicate that there is no further need of treatment. If the medical treatment must be extended to an illness or consequence of an accident, with no causal connection to the previously treated condition, then this is considered a new claim.
2. In so far as the tariff defines the relevant benefits, further grounds for a claim shall also be:
  - a) Medically necessitated treatment including pregnancy examinations, pregnancy treatments, in as far the pregnancy had not yet commenced at the beginning of the insurance relationship of the insured persons as well as treatment for miscarriage;
  - b) Medically necessitated pregnancy treatment due to acute complaints caused by and treatment due to miscarriage as well as medically necessitated abortions and deliveries up to the end of the 36th week of pregnancy (premature birth), even if the pregnancy had already commenced at the start of the insurance relationship of the insured person, if the necessity for treatment was not yet obvious at this time;
  - c) Deliveries after expiry of the waiting period according to the agreed tariff;
  - d) Outpatient examinations for early diagnosis of illnesses according to programmes and introduced to the Federal Republic of Germany and prescribed by statute (purposeful preventive medical checkups);
  - e) Death.
3. The nature and amount of the insurance benefits shall be derived from these conditions of insurance of the respectively selected tariff.
4. In the area of cover the insured person may choose from those medical doctors, dentists, licensed general practitioners specialised on alternative medicine and midwives who are practising on a legally approved basis in the insured's country of residence and who invoice on a locally customary basis or - if applicable - according to the official scale of charges for their profession.
5. Pharmaceuticals, bandages, medicines and medical aids must be prescribed by the qualified practitioners mentioned in conditions of insurance section I, B, I, §1, para. 4. Pharmaceuticals may also be obtained from a pharmacy. Nutriment, tonics, mineral water, disinfectants and cosmetics, mineral water, dietary, and baby food and the like are not considered pharmaceuticals even if they have been prescribed.
6. In case of medically necessitated hospital treatment, the person insured has free choice from among those public and private hospitals that are under constant medical supervision, possess sufficient diagnostic and therapeutic equipment and conduct case histories and do not provide health resort respectively sanatorium treatments or accept convalescent patients. Insurance protection is granted for the general class (multiple bedrooms) without coverage options (private treatment by doctor).
7. In case of medically necessitated hospital treatment in licensed hospitals, which also carry out health resort or sanatorium or convalescent treatments but which in other respects conform to the conditions of section I, B, I, § 1, para. 6, benefits at the agreed rate will only be paid if the insurance company has given written consent to this before the start of the treatment. In case of a TB condition, benefit will be paid to the extent defined by the contract for hospital treatment in TB treatment centres and sanatoria as well.
8. The insurance company will pay benefit to the extent defined by the contract for examination and treatment methods and pharmaceuticals that are generally recognised by school medicine. It will in addition pay benefit for methods and pharmaceuticals, which have proved themselves in practice to be equally likely to achieve success; the insurance company may however reduce the level of benefit to the amount that would have been paid if existing school medicine methods or pharmaceuticals had been used.
9. The insurance company will pay to the extent defined in the tariff the conveyance and funeral costs, if the death of an insured person is the consequence of an insured event.
10. The insurance company carries additional costs to the extent defined in the tariff for a medically necessitated return transport prescribed by a doctor to the nearest suitable hospital in the native country or to the permanent place of residence of the insured person. Medical necessity for a return journey is given, if it is proven that in the agreed tariff area sufficient medical treatment is not ensured and the return journey is recommended by the doctor of the insurance company. The costs of an also insured accompanying person are assumed, in as far the accompaniment is medically necessitated, officially ordered or required by the accomplishing transport company.

## **§ 2 SPECIAL EXCLUSIONS**

1. So far as has not been agreed to the contrary, there is no obligation to provide benefits for treatments by doctors, dentists, licensed general practitioner specialised on alternative medicine, hospitals or midwives whose invoices the insurance company has excluded from reimbursement on good grounds. Precondition for this is that the insurance company has notified the party entitled to insurance and the insured person before occurrence of the insured event and of the practitioner who will not be reimbursed. In so far as at the time of notification a claim should be pending, no obligation to pay benefit for the practitioner concerned shall exist for expenses incurred after the expiry of three months from the time of notification being given.
2. If the medical treatment or other measure for which benefit has been agreed upon should exceed the medically necessitated limits, or if the remuneration claimed is out of proportion, the insurance company may reduce benefit to an acceptable level.

## **§ 3 SPECIAL OBLIGATIONS AFTER OCCURRENCE OF THE INSURED EVENT**

1. The insurance company is to be notified of any hospital treatment within ten days from its starting.
2. The person insured must submit the relevant documentary evidence to the insurance company within three months from the time of each individual course of treatment.
3. If a person insured has concluded a contract for the insurance of medical expenses with another insurance company, if such exists or a person insured avails himself/herself of the entitlement to insurance in connection with statutory health insurance cover, the party entitled to insurance or the person insured shall be obliged to notify the insurance company without delay of the other insurance cover arranged.
4. The insurance company is to be informed of a case of pregnancy within four weeks after the existence of a pregnancy has been established, unless defined otherwise in terms of the relevant tariff.
5. The insurance company is to be informed of medically necessitated return transports before being carried out.
6. The legal consequences of a breach of one of these obligations are set out in conditions of insurance part I, A § 7, para. 4.

## **SECTION II SICKNESS DAILY ALLOWANCE INSURANCE COVER (ONLY VALID, IF CONTAINED IN THE SELECTED TARIFF)**

### **§ 1 OBJECT OF THE INSURANCE**

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company offers insurance cover against loss of income in consequence of illness or accidents either within Germany or abroad. In case of a claim arising based on inability to work, it will provide a daily sickness benefit allowance.
2. A claim shall exist in case of a proven inability to work in the course of medically necessitated treatment by a doctor. The claim shall be considered to

begin with the treatment, and shall end when medical findings indicate that the patient is no longer incapable of working.

3. It shall be seen as a case of inability to work in the sense of these conditions if the person insured, on the strength of medical evidence, cannot in any way exercise his or her profession, does not practise it and has no other means of gainful employment. If the medical treatment must be extended to an illness or the consequences of an accident which is unconnected, in terms of origin, with the condition treated hitherto, to that extent it shall be considered to be a new claim.
4. Insurance cover extends to a case of inability to work in the country of residence defined by the insurance agreement.

## **§ 2 SCOPE OF INSURANCE BENEFITS**

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company's obligation to pay benefit shall begin with the first day of inability to work, with the addition of any days without benefit that form part of the terms of the agreement (period of restriction). The obligation to pay benefit ends when the person insured is able to resume work or with the end of the insurance cover according to conditions of insurance part I, A, § 4, para. 5 conditions of insurance part I, B, II, § 4, but at latest with the end of the duration of benefit as defined in the given tariff.
2. The insurance company hereby undertakes to adjust the insurance cover with effect from the first of the following month after application has been made by the party entitled to insurance and the person insured, if and to the extent that,
  - a) through a change in the regular net income derived from professional activity an increase in the sickness daily allowance agreed upon is necessary, so as to maintain the previous percentage ratio between sickness daily allowance and net income. This obligation is also incumbent on the insurance company in case of a reduction in the level of a sickness benefit claim on a statutory benefit provider.
  - b) through a change in the duration of continued payment of salary, in case of inability to work, a switch to a different tariff level with a different waiting period should be called for.

This adjustment must be applied for within two months from the occurrence of the reasons for the change. The reasons for the change must be presented in a convincing way, and should be supported by documentary evidence at the request of the insurance company. In the case of current claims, the increased level of cover shall be allowed from the time when the change becomes effective.

3. If it should come to the knowledge of the insurance company that the net income of insured person has sunk below the level of the income on which the insurance agreement is based, it shall be entitled, without distinction as to whether an insurance claim has already occurred or not, to reduce the sickness daily allowance and the premium correspondingly, with retrospective effect from the onset of the reduction, or call for the reimbursement of benefit paid in excess.
4. The payment of sickness daily allowance is based on the assumption that the person insured will be treated by a doctor or in hospital for the duration of the period that he/she is unable to work.
5. In case of medically necessitated hospital treatment, the person insured has free choice from among those public and private hospitals that are under constant medical supervision, possess sufficient diagnostic equipment and conduct case histories.
6. In case of medically necessitated hospital treatment in licensed hospitals which also carry out health resort or sanatorium or convalescent treatments but which in other respects conform to the conditions of insurance part I, B, II, § 2, para. 5, benefits in terms of the given tariff will only be paid if the insurance

company has given written consent to this before the start of the treatment. In case of a TB condition, benefit will be paid to the extent defined by the contract for hospital treatment in TB treatment centres and sanatoria as well.

## **§ 3 SPECIAL EXCLUSIONS**

So far as it has not been agreed to the contrary, no benefit will be paid:

1. in a case of inability to work resulting exclusively from pregnancy, also from termination of pregnancy, miscarriage or childbirth. As an exception to this, benefit will be paid to individuals in a position of employment who are insured for the payment of sickness daily allowance with a waiting period (period without benefit) of at least 42 days, outside the statutory prohibitions on working in accordance with conditions of insurance part I, B, II, § 3, para. 2.
2. in case of inability to work during a period of statutory prohibition on working for expecting mothers in a position of employment and women in childbirth (maternity protection).

## **§ 4 ADDITIONAL STIPULATIONS ON THE END OF INSURANCE COVER**

1. The insurance cover comes to an end, in addition to the circumstances mentioned in conditions of insurance part I, A, § 4, para. 5 with the person insured's giving up gainful employment, with the onset of occupational disability or earning incapacity or a partial reduction of earning ability or when the person insured starts to draw an old age pension or pension for occupational disability or earning incapacity or for reduced earning capacity.
2. The insurance company will decide on the question whether, to what degree and starting from what time occupational disability or earning incapacity or reduced earning capacity has set in, on the basis of the documentary evidence submitted to or obtained by the company, and will communicate its decision on the matter in writing.

## **§ 5 SPECIAL OBLIGATIONS**

1. The insurance company should be notified immediately of a medically attested inability to work, through presentation of the appropriate documents. The doctor's certificate may be sent in advance by fax. The originals must be sent by post without delay. Certification by spouses or life partners, parents or children are not sufficient as a proof of inability to work. If notification is received late, the sickness daily allowance will be paid only from the day of receipt, not however before expiry of the period of restriction. Documentary proof of continuing inability to work should be regularly supplied to the insurance company, in so far as the insurance company does not request it on a different basis, at two-weekly intervals at most.
2. If a sickness daily allowance policy is concluded for a person insured with another insurance company, or if a person insured has recourse to the insurance entitlement included in statutory health insurance, the party entitled to insurance and the person insured shall be obliged to inform the insurance company forthwith of the other insurance policy.
3. The insurance company is to be notified without delay of any change of career by the person insured.
4. The party entitled to insurance and the insured person must immediately notify the insurance company of the termination of the employment contract between the party entitled to insurance and the insured person.
5. A new insurance policy with a third party insurer that includes a claim to sickness daily allowance may be taken out, or an existing one increased, only with the consent of the insurance company.
6. Persons insured are obliged to notify the insurance company immediately of a reduction in their net income derived from professional activity, if this is not just a temporary condition, or of a change in the duration of continued salary payment by their employer.